Qualitative Case Review

New Reviewer Training

Presented by
The Office of Services Review

Agenda

Agenda	**Welcome**
8:30 – 8:45	**Introductions**
8:45 – 9:00	**Working Agreement / Needs Assessment**
9:00 – 9:30	**Qualitative Case Review Overview (PowerPoint)**
9:30 – 9:45	**Protocol (Purple) Book and Pink Sheet Overview**
9:45 – 10:00	*Break*
10:00 – 11:00	**Protocol Group Exercise (Child Status)**
10:00 – 12:00	**Protocol Group Exercise (System Performance)**
12:00 – 1:00	*Lunch on your own*
1:00 – 1:30	**Rating Child and Family Status, and System Performance (PowerPoint)**
1:30 - 2:30	**Rating Exercise**
2:30 – 2:45	*Break*
2:45 –3:30	**Interviewing**
3:30 – 4:00	**QCR Certification / Reviewer/Shadow Instructions**

What is the Qualitative Case Review (QCR)?

The Qualitative Case Review is one of the steps in the DCFS Milestone Plan. It is an evaluation method used by the Office of Services Review (OSR) in conjunction with the Child Welfare Policy and Practice Group (CWPPG) to appraise the current status of children and their families who are receiving child welfare services and assess the performance of key system functions performed by the Division. While the current Case Process Review looks at the compliance of casework with state statutes and policy, this qualitative approach intends to evaluate the outcomes of the Division's interventions and the quality of casework practice. This is accomplished through in-depth interviews with individuals involved with a case. The families' perception of the Division and the services they receive, as well as the viewpoints of professionals involved in a case, is a key aspect of the review. Review results are used for understanding and improving the front-line practices of child-serving agencies.

The review tool, referred to as the protocol, reflects the Practice Model principles. It measures key system functions, such as family participation, teaming and coordination, assessment, service planning and delivery. For the current status of the child and family areas such as safety, well-being, and permanence are assessed. A summary of the protocol questions is available on the pink sheet.

Every region is reviewed and rated individually. There is one annual review session per region, lasting five working days. 24 cases are selected per region. Each case is reviewed by a team of two reviewers. Reviewers are chosen from within DCFS (experienced and qualified child welfare workers, supervisors, trainers, etc.) who are paired up with certified reviewers from OSR and CWPPG. Professionals from outside of DCFS, mainly partners in related fields, are also invited to participate as reviewers. A written report is submitted to each region for follow-up.

(For more information see: www.hsosr.utah.gov)

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QCR Overview
NOTES

Milestones Summary

Milestone 1. Practice Model Development, Training, and Implementation
This milestone details why a framework of practice is important for the Division, how the model for Utah is being developed, how staff and partners will be trained about the model, and what steps will be taken by the Division to implement the model and measure its effectiveness.

Milestone 2. System Investments
This section outlines historical growth, and current financial and technical supports which support the Division's provision of services to children and families. How the Division will retain staff, and recruit and retain foster families is answered in the section.

Milestone 3. System Management Structures
This milestone examines the principal management and administrative structures within the Division. These structures include the various management teams which work to direct the system and the necessary communication tools for providing information to the field about the direction of the Division.

Milestone 4. Priority Focus Areas
Over the past two years, the Division in conjunction with community partners has identified six areas for special attention. These areas include: CPS priority timeframes, proximity issues relating to out-of-home placement, health and mental health follow-up issues, regular visits and family engagement, barrier removal to kin placement, and placement prevention/disruption funds. The plan examines each of these areas and provides strategies to solve the problems associated with each specific focus area.

Milestone 5. Accountability Structures
This milestone outlines the internal and external structures that are in place for reviewing the Division work and practice as it relates to delivering child welfare services.

Milestone 6. Trend Data Analysis
This section reviews the Division's work in developing trend indicators to show progress in the areas of child protection, out-of-home services, and in-home services. The Division and the Child Welfare Policy and Practice Group jointly developed the 16 trend indicators that reflect the direction of national discussion as it relates to child welfare data trends.

Milestone 7. Case Process Review
Case process reviews have been used over the past four years to examine the performance of the Division in key case practice areas. This milestone describes how these reviews will be continued and how the data from the reviews will be used for system improvement.

Milestone 8. Qualitative Case Record Review
This milestone details a new review method for the Division. The Division along with the Child Welfare Policy and Practice Group will be conducting qualitative reviews of out-of-home and in-home cases in order to more directly assess the status of children and families with whom the Division is involved.

Milestone 9. Quality Improvement Committees
This milestone describes the charter of quality improvement committees. These committees, which will be developed in each Division region and at the state level, will be responsible for utilizing information from the data trends, case process reviews, and qualitative reviews to guide necessary change to ensure system improvement.

NOTES

Child and Family Status Indicators

Safety:
Stability:
Appropriateness of Placement:
Prospects for Permanence:
Health / Physical Well-Being:

Emotional / Behavioral Well-Being:
Learning Progress / Developmental Progress:
Caregiver Functioning:
Family Functioning and Resourcefulness:
Satisfaction:

System Performance Indicators

Child / Family Participation:
Child / Family Team and coordination:
Child / Family Assessment:
Long-Term View:
Child / Family Planning Process:

Plan Implementation:
Formal / Informal Supports and Services:
Successful Transitions:
Effective Results:
Tracking and Adaptation:
Caregiver Support:

Scoring

(Notes)

Scoring Child Status:

Timeframe Guideline:

Timeframe Exceptions:

Stability: Look back _____ months or to case opening, whichever is shorter. You will also need to look forward perhaps as long as _____ months.

Permanency: Evaluates the _____ between the child and caregiver.

Takes into account the _____ of that _____.

Therefore, it requires looking in the _____ and _____ into the future.

Scoring Exceptions

Safety:

Only indicator that _____

General Notes for Rating Status Indicators:

Scoring System Performance:

Look at the _____ of _____

Timeframe Guidelines for Acceptable Rating:

Rating 4:

Rating 5:

Rating 6:

Deciding between a 3 and a 4 (Page 59):

A rating of 3:	A rating of 4:

Groundhog Day Rule: _____

_____

Summary of Status Scoring:	Summary of System Scoring:
1 – Poor and getting worse 2 – Stuck 3 – Improving, but not okay yet 4 – Minimally acceptable right now 5 – Favorable and improving 6 – Optimal and sustainable	1 – Absent 2 – Fragmented, Incomplete 3 – Underpowered 4 – Minimally adequate 5 –Working well over time 6 – Exemplary over time

Scoring Practice		
Case	**Indicator/Score**	**Narrative**
1	**Safety**	Although there are risk factors within the family situation, Father is not known to have any involvement with drugs and Child feels safe in his home. Although there are concerns about his pull toward gangs, there are differing opinions about his actual involvement and no one had specific information about it. There are, however, reasons to continually assess **safety** and to focus the team on the issues.
2	**Stability**	The child has experienced **stability** since her entry into foster care fourteen months ago unlike her life experience in her mother's care for several years prior to placement. Not only has she been in only one foster home since reentering care, this family is committed to her and views their home as the place she will be until she reaches adulthood.
3	**Prospects for Permanency**	Child's current placement is one that every team member feels will endure until he reaches maturity and beyond. Safety and stability have been achieved. With the exception of guardianship issues not being resolved, the sense and feelings of permanency in this case are very strong and are perhaps even more likely to endure throughout the child's life than a placement that has been made "legal" through a court order. A stronger indication of **permanency** may be found in the strength of familial identity and commitment that is shared between a child and his caregivers. The foster parents love the child and his brothers as their own and are committed to them for as long as they live. Each member of the Child and Family Team emphasized the connection and familial identity that the child and his brothers have in this home. The AAG states that "the boys see the foster parents as their family, they will be there for them beyond the age of 18, and this placement is a long term committed placement." The child has lived in their home since June 2001.
4	**Emotional / Behavioral Well-Being**	The child remained in the A&D unit for approximately three months. He indicated that he knew that his attitude was not what it should be before entering this program. Although he did not elaborate he did indicate that he attributes "lock up" with a positive "change in attitude." This is allowing him to make progress **emotionally and behaviorally**. This is evidenced by the work he is doing with regard to his relationship with his mother and by the fact that he has remained clean and sober during the month and a half since leaving the locked facility. His current therapist is working closely with him to empower him and enable him to set effective boundaries with his mother.

5	**Child and Family Team and Coordination**	The **team** appears to be primarily the current PSS worker and the mother. It is not clear that everyone with important knowledge or influence meets regularly to update assessments and contribute to a planning process that is viewed as integrated and constructive. The exclusion of Mother's family members may have been well intended, but appears to have contributed to her perception that she is "fighting alone."
6	**Child and Family Assessment**	The written **assessment** document did not reflect an understanding of the family's underlying needs and was often an observation of conditions or events without a determination of need. For example, the assessment of protection factors described the children's current situation rather than the issues and factors that necessitated the system response or continued to require attention, particularly the mother's role with the family. There is no understanding of the causes of the father's use of alcohol. Everyone remains concerned about what will happen if the mother returns, but there is no assessment of the family's relationship to her and what is needed to plan effectively.
7	**Long-Term View**	All team members are aware of the **long-term view**, that of assisting the child to successfully complete her high school education and preparing her to live independently after graduation. They are aware that she has completed three domains in the Independent Living module and that she will soon be attending Independent Living classes through DCFS. Transition plans to meet the LTV are in place.
8	**Child and Family Planning Process**	There is not a formal **plan** that details how the father's sobriety will be supported after he exits the system, nor how relapse could affect the case. Including these areas in a coordinated plan would allow for a long-term view of how the family will live successfully, independently of DCFS involvement. There are many services and supports in place that will permit success but there is a lack of common vision of how the plan will eventually achieve independence.
9	**Plan Implementation**	In spite of the service plan's shortfalls, services have been **implemented** in a timely and competent manner and the intensity of services has led to desired results over the past two months. The array of services provided by the State Hospital is helping the child reach a favorable level of functioning socially, emotionally, and academically. The family therapy that commenced two weeks ago is expected to meet the family's need to reconcile relationships and avoid mother/daughter conflict in daily living and decision making.
10	**Tracking & Adaptation**	The caseworker has considerable contact with the family and service providers which allows for **tracking and adaptation,** although the team is not together on its role in adapting to emerging needs and has missed some concerning areas. Some core areas are unacceptable as a result but this level of involvement could result in response to concerns, especially if the team is gathered to make critical adaptations.

Interviewing

You don’t have a script for interviewing!

Introducing yourself

Starting the interview

Allow the interviewee to tell the story

Interviewing adolescents

Interviewing young children

Using your shadow

Gathering necessary information – Pink sheet – Wheels

Strength based approach

Gathering information Vs. “Fixing” the case.

Qualitative Case Review "Utah"
Illustrative Case Story *"April";* **QCR-Number:** UT99

Date of Qualitative Case Review: September 2003

Reviewers:
Kelly
Greg

FACTS ABOUT THE CHILD AND FAMILY

Family Composition: April is a 15-year-old female who is in a foster care placement at the Utah State Hospital. Her family consists of Sally (mother, age 39), Roxanne (half sister, age 23, married with one child), Ashley (half sister, age 21, married), Don (half brother, age11) and Kim (half sister, age 7).

These five family members along with Roxanne's husband and child live together in the same home. Sally's father resides in California. He and her mother separated when she was a toddler. She has not lived with him since that time, but she has had ongoing phone contact with him and has visited him regularly in California.

Prior CPS Investigations and DCFS Involvement: In 1995 there were substantiated allegations against Sally of emotional maltreatment and failure to protect. In 1999 there was a substantiated sex abuse allegation in which April was the victim. The perpetrator did not reside in the home and the allegations did not result in a removal.

The current foster care episode began after services that Sally had obtained privately to deal with April's ungovernable behavior had failed to effect a change. Sally voluntarily placed April in state custody in order to access additional services.

Permanency goal: Individualized Permanency

The reviewers interviewed:
Target Child, Caseworker, School Teacher, Therapist, Psychiatrist, Psychologist, Nurse, Guardian ad Litem (by phone), Assistant Attorney General (by phone), and Mother.

CORE STORY FOR THE CHILD AND FAMILY

April is one of five children of her mother, Sally, who is currently a single parent. April became increasingly ungovernable as she entered her teenage years. She was abusing alcohol and drugs, having sex with many different partners, and acting defiantly toward authority figures. She was frequently truant and her manner of dress was described as immodest and extreme. She was also involved in illegal activities such as shoplifting.

Sally was concerned for April's safety and health and feared she would soon have an unwanted pregnancy. In an effort to address these concerns, Sally placed April privately in Lifeline, a residential treatment facility. April assaulted a staff member there and was kicked out of the program. Following her expulsion, she was briefly at UNI (University of Utah Neuropsychiatric Institute), another residential treatment facility. From there she returned home.

April returned to her home with little or no improvement in her behaviors. She soon attempted suicide via an overdose and ended up in a local hospital. The hospital psychiatrist advised Sally that in order to get the help she needed, April would have to be placed in the custody of the state. Although it was difficult and emotionally traumatic for Sally, she decided to legally "abandon" April so she could be placed in state custody and receive the intensive services that she needed.

April came into care in August 2002. After an initial shelter placement, she was placed at ARTEC where she assaulted a staff member and was ejected from the program. They refused to take her back.

After a month in detention April was placed in another residential facility, the Better Be Ranch. She was evicted again due to assault charges and they would not take her back.

By January 2003 April had accrued five assault charges. The team was uncertain what approach to take with her. They vacillated between placing her in a wilderness program and placing her at the Utah State Hospital. Her case was screened by a placement committee. A member of the committee who was affiliated with a local mental health agency felt that she was a good candidate for the State Hospital and advocated that she be placed there.

April was placed in the State Hospital in February 2003. Due to her history of assaultive, aggressive, and socially inappropriate behaviors, she was placed on the Conduct Track. She spent the vast majority of her first five months on Level 1 of a four-level program.

Concerned staff members drew the treatment team's attention to the fact that April was not responding to the conduct program as expected. Teens with conduct disorders typically responded to the program in a matter of weeks, while April had been in the program for five months with little or no progress. Staff members recommended further assessment to see if there might be a better alternative for her.

Coincidentally, April got sick about this same time. She was diagnosed with Serotonin Syndrome, a reaction to being on too many medications that stimulate serotonin production. At the time of the reaction April was on Seroquil, Paxil, Trileptol, and Depakote. She was taken off all of her medications. Rather than deteriorating, her behavior began to improve. April felt more in control of her behaviors and was less anxious. It was just after this that the psychologist began to do further testing on her.

After extensive and thorough testing, April was diagnosed with an organic brain disorder known as Executive Functioning Disorder. This disorder inhibits one's ability to control dangerous impulses and evaluate consequences. Although Sally has not used drugs for six years, she was a heavy methampetamine user while she was pregnant with April. Recognizing this risk factor was important in identifying the disorder.

With the new diagnosis the staff was able to adjust the conduct program to meet April's needs. Rewards were given immediately and more frequently and gentle prompts were given. April soon began to comply with the program and think through her choices prior to making them.

It was also a big relief to April to know that there was a legitimate medical explanation for her behavior; she was not just an inherently

bad person. She had believed that there was no chance of her changing or improving.

April is an unusually bright young woman. She understands the diagnosis and the reasons for the changes in her program. She has been responding very well to the prompts she has received. She is now on Level 4 and her therapist is planning on discharging her from the hospital in a couple of months.

April is safe in her placement at the State Hospital. There are no safety risks to her from others and she is only a slight safety risk to herself. She will occasionally scratch herself until she creates a sore, but she has not done so since June and there is a plan in place to help her deal with it if she gets the urge. She is no longer a suicide risk and she does not threaten staff or peers. In fact, she has become somewhat of a peacemaker between different cliques of girls at the hospital.

Since being placed in the State Hospital in February, April has stabilized in her placement; however, the protocol requires reviewers to look at the entire year prior to the review. During that time she disrupted two residential placements, had two stays in detention, and was twice placed in shelter at Vantage Point. She is on the verge of another move as she will soon transition out of the State Hospital.

The State Hospital is a very appropriate placement for April. Taking a mental health approach rather than a punitive approach to her treatment has proven effective. Although this is a very restrictive setting, it is the least restrictive setting that is appropriate for her. She is benefitting from the structure and the opportunity to learn social skills among peers of her own age. She receives the constant supervision, prompts, and support that she needs to reawaken the executive functioning capacity of her brain.

April is in generally good health and her basic physical needs are met. She complains periodically of nondescript abdominal pain. She has seen a physician for this but no cause has been identified. Staff members suspect that her abdominal pain may be somatic since it usually occurs just prior to something she doesn't want to do, such as attend gym class. She is receiving good dental and orthodontic care. Her braces will be removed in two months. She is on only one medication and that is to address chronic insomnia.

April is doing better emotionally and behaviorally than she has done in years. Although social skills have been a major challenge for her in the past and she was formerly described as obnoxious and intrusive, she is now accepted by the other girls at the hospital. She has not had an assaultive incident since her early days at the hospital. She has stabilized in her treatment and is making reasonable progress toward discharge. She participates in group, individual, and family therapy.

April's progress in school has been very good. The local school district provides a teacher to the State Hospital and April attends school on site. She is in a class of fewer than a dozen students where each student is allowed to progress individually. She has successfully made up past credits and is earning good grades. She is at or above grade level in all but math.

It is expected that she will be mainstreamed back into a local public high school upon discharge. Social and emotional supports will be required, such as a counselor who is aware of her issues and who can provide support when needed, but she is not expected to need academic supports. Careful selection of teachers will be important because April responds particularly well to some teaching styles and poorly to others.

The team has identified April's next placement as a structured foster home, though the specific home has not been identified. Team members believe she will do well in a home where there are only one or two other children (preferably good role models who are near her age) and there are clear boundaries. It needs to be a home where she receives frequent praise,

consistent reinforcement, gentle prompts, and monitoring of her social skillls. Finally, the foster parents need to listen to her and genuinely care about her.

The team is identifying the supports that April will need to succeed in the settings of structured foster care and public school. Key members of the team have knowledge of what it will take for her to succeed, but this information needs to be gathered and assembled into a holistic plan. Post-discharge services are expected to include family therapy, individual therapy, structured foster care, medication monitoring, and casework services.

There is a history of conflict between April and her mother and between April and her oldest sister. There is concern that April and her older sister cannot live peacefully under the same roof. Conflict between April and her mother is being addressed in family therapy. Both parties have a desire to improve their relationship. Short visits go well, but visits that last for days get stressful for both as they begin to fall into old patterns.

The family is under a good deal of financial stress. Sally exhausted her retirement funds and her insurance on private services to help April prior to her coming into custody and has an outstanding debt she must repay to one residential treatment facility. Financial pressure increased when April came into care because the child support that Sally had been receiving now goes to the State of Utah. Finally, having April's oldest sister, husband, and baby living with the family is increasing the financial and emotional strain on Sally. In spite of these challenges most of the family's fundamental needs are met.

April is unusually bright and determined to succeed. Her mother is very involved in her care and is willingly participating in family therapy. She has called April almost daily and visted her weekly. Each wants the relationship with the other to be better. Building on these strengths, family functioning is expected to continue to improve.

April has made consistent progress for two to three months. She has substantially improved her functioning in key areas. Her progress has been carefully tracked on a daily basis by State Hospital staff via a system in which she collects signatures and tokens for appropriate behaviors for different daily activities such as dressing for school, behavior in school, etc.

Both April and her mother expressed satisfaction with the services and supports that they have received. They have regular contact with the worker and feel that she is responsive to their needs. April was a little less satisified with her level of participation and input than her mother was with her own, but both strongly agreed that they are benefitting from the services.

Factors Contributing to Favorable Results

Child and family participation in team meetings has been good, especially considering the institutional setting in which these meetings are held. April's mother has participated in all but one of the team meetings. Although these meetings are technically monthly staffings that are conducted by the hospital st[illegible] the caseworker and April's mother have been full participants in the meetings. Both report that their input is both sought and heard and they are able to influence decisionmaking. On the other hand, meetings were set to accommodate the hospital staff rather than being scheduled at times convenient for the family and hospital practice is that most of the meeting is held without April, then she is brought in for the last ten minutes. The caseworker does her best to represent April throughout the meetings.

The team contains the important decision makers and nearly all of them were aware of April's current status, including the decision to discharge her which had been made just days prior to the review. Most team members viewed the worker as their point of contact. Services and supports are coordinated and modified continuously by the team. Hospital staff reported good support from the

caseworker who was readily accessible and generally responsive to needs.

Although the DCFS Functional Assessment document itself was rather narrow, assessment by the provider has been excellent. Team members appear to understand the major underlying needs of April and her family. The in-depth testing and assessment done by the State Hospital psycholgist appears to have been the turning point in the case and the key to April's recent success.

Team members share an implicit long term view that April will be discharged from the State Hospital and placed in a structured foster home where she will work toward returning home. If reunification is not successful, she will pursue independent living while remaining in a foster home. The team has identified the next major transition (discharge from the hospital) and has begun to plan the transition based on the long term goals.

Services have been implemented in a timely and competent manner and the intensity of services has led to desired results over the past two months. The array of services provided by the State Hospital is helping April reach a favorable level of functioning socially, emotionally, and academically. The family therapy that commenced two weeks ago is expected to meet the family's need to reconcile relationships and avoid mother/daughter conflict in daily living and decision making. April and her mother cited strong informal supports consisting of friends, a large extended family, and a religious congregation.

Factors Contributing to Unfavorable Results

The Child and Family Plan addressed needs in a generic way. Additionally, although circumstances in the case have changed markedly over the past six months, the Service Plan prepared just last month was nearly a carbon copy of the former Service Plan that was implemented six months ago. It would be difficult for someone to step into this case and use the case plan to guide case planning in a meaningful way.

The reviewers identified the following system barriers:

1. Lack of therapeutic foster homes in the Provo area.
2. A requirement that children be legally "abandoned" by their parents in order to get state services.

Stability of Findings

April's status is expected to improve over the next six months as she continues to respond to treatment. Progress over the past few months has been excellent since the discovery of her organic brain disorder and the modification of her behavior program and medications. April appears to be determined to continue h progress.

Practical Steps to Sustain Success and Overcome Obstacles

Prepare the members of the Child and Family Team who are not members of the State Hospital staff to assume a larger role than they have had to assume while the hospital has been involved. Increase April's participation, in particular, and help her mother to assume more of a leadership role in planning for the future and addressing family issues such the older sister and her family moving out.

Update the service plan and assure that it is individualized and relevant to April's needs. Assure that needs such as substance abuse treatment and past sex abuse issues that have been lesser priorities while she has been in the State Hospital are addressed.

Hold a Child and Family Team Meeting to plan and prepare for transitions around April's upcoming discharge. Gather information from key team members such as the school teacher and therapist. Assure that a new therapist is in place in ample time to transition April from her State Hospital therapist to the

new therapist and that a transition meeting is held with the school.

Assess April's possible need for school clothing. Many of her clothes no longer fit due to weight gain during her year in care, a side effect of some of her medications.

Per the DCFS supervisor's recommendations, explore the possibility of providing voluntary services to assist the oldest sister and her family to move out on their own and waiving the ORS payment to relieve financial stress on the family.

Child Status and System Performance Ratings

Child Status	Rating	System Performance	Rating
1. Safety		1. Child and Family Participation	
2. Stability		2. Child and Family Team/Coordination	
3. Appropriateness of Placement		3. Functional Assessment	
4. Prospects for Permanence		4. Long-Term View	
5. Health/Physical Well-Being		5. Child and Family Planning Process	
6. Emotional/Behavioral Well-Being		6. Plan Implementation	
7. Learning Progress		7. Formal & Informal Supports & Services	
8. Developing/Learning Progress (under 5)		8. Successful Transitions	
9. Caregiver Functioning		9. Effective Results	
10. Family Functioning and Resourcefulness		10. Tracking and Adaptation	
11. Satisfaction		11. Caregiver Support	
12. OVERALL STATUS		**12. OVERALL PERFORMANCE**	

Qualitative Case Review Results

Outcome:

1: pos. child status and pos. system performance ☐ 2: neg. child status and pos. system perf. ☐
3: pos. child status and neg. system performance ☐ 4: neg. child status and neg. system perf. ☐

Debriefing Outline

After interviewing all parties involved with the case and studying the case file, a case debriefing will be held to discuss the case specific findings and provide assistance if reviewers are struggling with certain scores. Other reviewers, the case supervisor, and the region director (or other members of management) will be present as well. Not only is the debriefing to discuss strengths and areas where the reviewers are struggling with ratings, it is also to help clarify the rationale behind the reviewer's judgements and recommendations. If the reviewers have difficulties rating a domain, they can discuss this with the group during the debriefing. The following outline is intended to give structure to the debriefings and guidance to the reviewers.

- Ideally, the interview schedule is set up so that you will be given some time (hopefully a couple of hours) between your last interview with the caseworker and the start of the debriefing to go over your findings with your review partner and rate domains in the protocol. Please use this time to complete your ratings and prepare for the debriefing. See preparation sheet on the back.
- Please plan on attending all debriefings. It is a good way to learn more about the review process by listening to experienced reviewers. It's also part of the certification process.
- During the debriefing, each reviewer team will be given **twenty minutes** per case. Please try to follow the following outline while presenting your findings.

5 minutes	Tell the core story for the child and family
10 minutes	Briefly discuss your findings regarding the child status and the system performance. What are the main themes/issues/concerns? What are the main factors contributing to a positive/negative child status? Which system functions need most attention?
5 minutes	6 months prognosis for the target child Recommendations, answer questions from other participants

- After the review, the lead reviewer will have ten days to write the case story, send it to his or her review partner for revision, and e-mail it to the Office of Services Review. If the lead reviewer decides to change some of the original ratings, he/she will discuss the changes with the review partner and inform the OSR about the change and the reasons for it.

Reminders:

* In order to follow the principles of the Practice Model remember to give feedback in a constructive way, including improvement needs as well as strengths.
* We rate results/outcomes, not intentions.
* We rate the current child status, not the past or future.
* This is a review of the system, not of the caseworker.
* Try to be consistent while rating domains, i.e. if the child's caregiver's functioning fails, then the child's safety will probably too.

Preparation Sheet for Case Debriefing

The debriefing is meant to be a place where you can discuss your findings and any difficulties in rating the domains. This paper can be used by reviewers to write down notes in preparation for the case debriefing.

QCR-Case #: _____ Case type (in- or out-of-home services): _____
Child's name: _____ Child's age: _____
Family composition: _____
_____

Core story: (use about 5-10 minutes to provide the important facts related to the child and family up to this date), include reasons for DCFS involvement, how long DCFS has been involved for, current and past placements, current permanency goal and concurrent goal, progress achieved.

Child status: Discuss your findings related to the current status of the child, such as safety, child well-being, placement/caregiving, and permanency. What are the main factors contributing to a positive/negative child status? Make sure you explain your findings on safety.

System Performance: Discuss your findings related to the system performance, including strengths of the caseworker, favorable system functions, and system's barrier to achieving better outcomes, if any. What are the main themes, issues, concerns?

6-months prognosis for the target child:

Recommendations:

Process for Utah QCR Certification	
Classroom Training	• Reviewer in development has completed all practice model training available (to date) • Complete pre-review classroom training covering the QCR Protocol, philosophy, methods, example applications, performance of essential functions • Complete a follow-up day of training following the first review for refinement of skills
Shadow Experience	• Shadow an experienced CWG reviewer in at least one on-site review • Act as a lead reviewer in at least one review under the guidance of an experienced CWG reviewer • Achieve acceptable concurrence with the experienced CWG reviewer on the Agreement Checking Procedure • Write at least one illustrative case stories and discuss feedback with an experienced reviewer
Evaluation	• Decide with an experienced CWG reviewer personal readiness to act as a lead reviewer and/or • Decide what additional coaching or practice is needed.
Certification	• A reviewer in development must receive a recommendation from an experienced CWG reviewer that he/she is ready to act as a lead reviewer

Notes:

Qualitative Case Review: Reviewer/Shadow Instructions

- **Reviewer Introduction: Please be present on Monday morning, usually at 8:30 a.m., for the reviewer introduction, as the last instructions will be given to you and you will be introduced to your review partner. The schedule is tight, so please be on time.**

- **Set up "last minute interviews": If during the course of the review a reviewer team decides to conduct and interview with someone who has not yet been scheduled, they can ask the review coordinator or office contact to set up this interview for them.**

- **Ground Rule: If the reviewer team has difficulties deciding on a rating, use the following rules:**

  - **Preponderance of evidence: If evidence points to a "4". But there are some elements of a "3", then use the rating "4";**
  - **If all else is equal, use the lower rating;**
  - **Use the Ground Hog Day Rule: If the case were to freeze in time and not change from how it is today, would it be all right?**
  - **When in doubt, refer to page 61 of the protocol and (*6-Point Rating Scales to Report Exam Findings and Differences between Ratings 3 and 4*);**
  - **Discuss your rating difficulties in the debriefing**

- **QCR Score Sheet: After the review team has rated all of the indicators in both domains, they need to fill out the QCR Score sheet with their ratings. The Office of Services Review (OSR) will enter the numbers in the computer in order to generate the Overall Child Status and Overall System Performance score. Please give the original score sheet to OSR staff member for case computation; they will keep the original and make a copy for your records with the computated results.**

- **Red-flag cases: If the case reviewed raises serious concerns regarding the safety of the children, the following procedure needs to be followed:**
  1. **Staff w/OSR Coordinator and Region Administration, ASAP**
  2. **If you can not find OSR Coordinator – staff with Region Administration, ASAP**

- **Rating changes: If the reviewer team decides to change some of the rating after the debriefing, be sure they are clearly discussed in the Case Story.**

- **Case Story write-up: After completing the case review, the review team has 10 calendar days to write the case story, using the Word form sent to you by e-mail. The lead reviewer will be in charge of writing the case story and sending a copy to the shadow for approval (make sure you exchange e-mail addresses with your review partner). The story should not exceed 8 pages, including the scores on the last page. Please e-mail your story no later than 10 days after the review to klambert@utah.gov and send the protocol to the Office of Services Review, State of Utah, 120 North 200 West, Room 313, Salt Lake City, UT 84103.**

  The OSR will send all stories to the regional administration, Division administration, caseworker and supervisor. If they find significant factual errors, we will contact the reviewer team to discuss the issues or to request a change. The final decision whether to change the story or not stays with the reviewer team. The region also has the option to appeal that decision to the Division Director.